AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

May 21, 2019

Chairman Lloyd Doggett
Ways and Means Committee
Subcommittee on Health
1102 Longworth House Office Building
Washington, DC 20515

Ranking Member Devin Nunes
Ways and Means Committee
Subcommittee on Health
1139 Longworth House Office Building
Washington, DC 20515

Chairman Doggett and Ranking Member Nunes,

Thank you for the opportunity to provide comments in advance of the subcommittee's hearing on surprise billing. On behalf of the 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we look forward to serving as a resource to you and to the committee as you work towards a solution for unexpected out-of-network medical bills.

Our membership is dedicated to providing high-quality care to patients, whom we believe must be held harmless and removed from the middle of billing disputes. AAOS is committed to collaborating with you on a federal solution that protects patients from unexpected out of network medical bills without compromising access to care through unintended consequences.

Ensuring Network Adequacy

Since the passage of the Affordable Care Act, insurers have created products with narrow, inadequate, and non-transparent networks. Insurance companies sell those inadequate products and fail to appropriately disclose the realities of the coverage their customers are purchasing. This results in narrow networks and, when insurance companies fail to properly inform customers, the "surprise" part of a surprise bill. With the growing prevalence of these highly-profitable narrow networks, opaque and overly complicated plans have prevented patients from having a full understanding of the nuances of their coverage. As a result, patients may unknowingly receive out-of-network care and are charged high out-of-pocket fees.

To ensure network adequacy, any proposal should require insurers to:

- Design networks with a specific minimum number of active primary care and specialty physicians available, adjusted by appropriate population density and geographically-impacted factors;

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- Maintain and robustly enforce accurate and timely physician directories to prevent carriers from continuing to provide patients with inaccurate directories;
- Provide accurate and timely fee schedules to patients and physicians to improve cost transparency;
- Offer out-of-network options to ensure that patients have choices when their network does not offer access to the physicians patients need; and
- When there are no specialists in a network who can meet a patient's need and a non-network provider must deliver specialty care, insurers should compensate those providers at their full fee. In these cases, the insurer has created an inadequate network, and they should bear the entire responsibility of ensuring patient access outside of what is available in the network.

In addition, states have a patchwork of network adequacy laws and regulations, with varying staff sizes, proactivity/reactivity in monitoring, and politicization of the insurance commissioner role. Enforcing network adequacy requirements is essential to protecting American healthcare consumers, and a federal solution is necessary to prevent the administrative and compliance burdens that result from so many different network adequacy standards.

Holding Patients Harmless

We support proposals to take patients out of the middle and hold them harmless for out of network emergency care. Insurance plans should reimburse providers directly with patients responsible only for the amount they would have paid in-network.

AAOS believes that in nonemergent situations, balance billing should be permitted if the patient is adequately informed about the likelihood of out-of-network care. The patient should have every opportunity to seek care from their preferred provider to preserve choice and competition.

Fair and Timely Payment

New York's law stipulates that insurers must develop reasonable payment rates for out-of-network care and illustrate how their out-of-network payments were calculated. Usual and customary rates are defined in the New York State law as the 80th percentile of charges based on the FAIR Health database. FAIR Health is an example of an independent and trusted database, relied upon by New York and other states. The law also requires new disclosures to patients regarding costs or network status, as well as hospital audits by the New York State Department of Health to ensure compliance.

The New York Model

In 2015, New York State enacted the most ambitious patient protections act for out-of-network medical services and the law is a success. Prior to this, insured patients were getting surprise bills because someone who treated them was out of network (unbeknownst to the patient), with providers charging patients the difference between hospital charge rates and the plan's out-of-network coverage.

Almost immediately after the New York law passed (and before the required implementation date), there was a marked reduction in out-of-network billing in the state. The out-of-network rate in New York in 2013 was 20.1 percent. Two years later, the rate was 6.4 percent, and the reduction in out-of-network rates was driven by reductions in out-of-network rates across nearly all hospitals, including those that previously had high rates of out-of-network billing.

The New York law has two components. The first is a hold harmless provision that prohibits balance billing patients and requires patients who are treated by an out-of-network physician to pay no more than what they would have paid in cost sharing should the physician have been in-network. The second component is an arbitration process to determine what providers are paid when they treat a patient and do not participate in the patient's insurer's network.

The AAOS supports using an independent database as an alternative to setting payment to "median in-network amounts," as some proposals suggest. With an artificially set rate insurers would have little incentive to negotiate in good faith with on-call providers and could instead rely on the statutory rate. This removes any market forces that draw the best providers to areas where their services are most needed and does not take into account cases where the minimum payment standard is insufficient due to the complexity of the patient's medical condition or other factors. For example, while the AAOS appreciates that the Senate Working Group on Health Care Price Transparency has proposed legislation that contains an arbitration option, that proposal still relies on the median in-network rate which is not workable in every case.

Hospital Bundled Billing

One option that's been discussed involves "bundled billing" of hospital payments, requiring hospitals to negotiate with the health plans on behalf of any provider that sees patients at that facility. Independent billing by physicians would be barred. Emergency and ancillary physicians would contract with the hospitals, not the health plans. Services would be bundled into the facility rate negotiated between the facility and the health plan, similar to how nurses contract with facilities.

Requiring hospitals to negotiate for independent physicians would require significant government intervention and fundamentally change the market. Instead of insurers "buying" services from these specialties, hospitals would be the "buyer" of these specific physician services and the seller of combined physician and facility services. This untested and

administratively complex proposal could exacerbate the consolidation of health care, allowing hospitals to set a universal rate for services and threatening the independent practice of medicine.

According to some estimates, 25 states have enacted some type of protection for out-of-network billing, with solutions spanning a wide range of techniques and comprehensiveness. No state has chosen this bundling option, and therefore there's no precedent to help policymakers understand how this could work in a real-world situation.

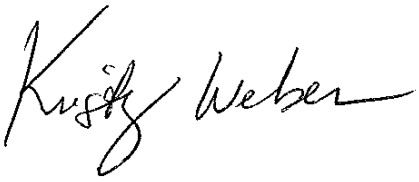
Bundled billing also doesn't consider what could happen if the hospital and insurance company can't come to an agreement to be in-network. In that case the physicians at the out-of-network hospitals would be unable to negotiate to be in-network and care for more patients.

Conclusion

The AAOS thanks the subcommittee for its attention to this issue and urges you to consider solutions for unexpected out-of-network bills that focus on protecting the patient, setting up a process for fair payment and preserving high quality care.

We invite the subcommittee to call on us as an involved partner during this process and look forward to working with you and other stakeholders. Please contact Jordan Vivian in the AAOS Office of Government Relations at vivian@aaos.org or 202-548-4153 with any questions or if the AAOS can further serve as a resource to you.

Sincerely,



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